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CUSTOMER SERVICE FORM

Purpose: *This form is to be used by Local Management Entity (LME) staff to document customer service issues such as concerns, complaints, compliments, investigations and requests for information involving any person requesting or receiving publicly funded MH/DD/SA services from a LME or a MH/DD/SA service provider.*

Tracking #: _____

Person reporting customer service issue: **Date:** _____

Name: _____ Phone: H: _____ W: _____ C: _____

Address: _____

Person reporting customer service issue is:

☐ Anonymous ☐ Attorney ☐ Client ☐ Client advocate/representative ☐ DMH/DD/SAS staff ☐ Family member
☐ Parent/Guardian ☐ LME Staff ☐ Provider ☐ Other (specify): _____

If customer service issue involves a client:

Client name: _____ Phone: H: _____ W: _____ C: _____

Address: _____

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female Disability (check all that apply): ☐ MH ☐ DD ☐ SA ☐UNK ☐N/A

County of Eligibility: _____ Home LME: _____ Host LME: _____

Parent/Guardian: _____ Phone: H: _____ W: _____ C: _____

Address: _____

Funding Source(s): ☐ County Funds ☐ Health Choice ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ State Funds ☐ Self-pay

Customer service issue was received via:

☐ Call ☐ Customer Service Form ☐ Email ☐ Fax ☐ In-person ☐ Website ☐ Written Correspondence

If issue was referred to the LME, indicate referral source and specify which LME or office:

☐ Another LME ☐ County Office ☐ Provider's Office ☐ State Office ☐ Other

(Specify): _____

Type of Case: ☐ Complaint/Concern ☐ Compliment ☐ Information/Referral ☐ Investigation **Priority:** ☐ Routine ☐ High

Nature of primary customer service issue. Issue is related to: (Check only 1 Primary Issue)

☐ Abuse, Neglect, Exploitation	☐ Failure to Respond to Complaint	☐ Quality of Care	☐ Service/PCP/Discharge Plan
☐ Access to Services	☐ Incident/Safety Concern	☐ Referral Process	☐ Service Authorization
☐ Client Rights	☐ LOC or Treatment Decision	☐ Resource Information	☐ Service Denial, Reduction, Suspension or Termination
☐ Communication Issue	☐ Medication	☐ Respect/Courtesy	
☐ Compliance with Rules	☐ Paperwork	☐ Responsiveness	☐ Service not meeting needs
☐ Confidentiality/HIPAA	☐ Payment/Billing	☐ Service Coordination	☐ Staff Person
☐ Cultural Sensitivity Issue	☐ Physician	☐ Service Provider	
☐ Facility Related	☐ Provider Choice	☐ Other (specify): _____	

Customer service issue notes: *(Attach additional pages if needed)*

If customer service issue is about a provider or agency: **Provider Category**: ☐ A ☐ B ☐ C ☐ D

Provider/agency name: _____ Phone: _____ Fax: _____

Address: _____

Type/Level of Service: _____ Licensed: ☐ Yes ☐ No By Whom : ☐DFS ☐ DSS

Did the person discuss the issue with the provider/agency? ☐ Yes ☐ No

Did the person give permission to use his/her name during discussion about this issue with the provider/agency? ☐ Yes ☐ No

Action taken by LME:

- ☐ Shared the customer service issue with the provider/agency/person(s) involved.
- ☐ Provided the information requested.
- ☐ Facilitated informal discussion/resolution with the provider/agency involved.
- ☐ Facilitated informal discussion/resolution within the LME.
- ☐ Provided information on how to initiate a Medicaid appeal or LME complaint process.
- ☐ Conducted Investigation. Person(s) investigating concern: _____

  Concern was: ☐ Substantiated ☐ Partially Substantiated ☐ Not Substantiated.

  Date report of findings issued: _____ Number of days from date received until report of findings issued: _____

  Based on findings: ☐ No further action needed ☐ Recommendations provided ☐ Corrective Action Plan required

  Date Plan was received: _____ Plan was: ☐ Accepted ☐ Returned For Revision

  Date Plan was resubmitted: _____ Resubmitted Plan was: ☐ Accepted ☐ Not Accepted

  Date of Follow-up review: _____ Corrective actions were: ☐ Successful ☐ Unsuccessful

- ☐ Referred to: ☐ DFS ☐ DMH/DD/SAS ☐ DSS ☐ Other (Specify) _____ Date: _____

  For: ☐ information ☐ action (specify): _____

  Date report received from: DFS _____ DMH/DD/SAS _____ DSS _____ Other _____

  No. of days before receipt from: DFS _____ DMH/DD/SAS _____ DSS _____ Other _____

Summary Of Issue(s), Investigation, and Actions Taken *(Include dates) (Attach additional pages if needed)*:

Final Disposition:

Action(s) taken *(include dates)*:

Issue(s) was(were): ☐ Resolved/Completed ☐ Partially Resolved ☐ Unresolved

Resolved by: ☐LME ☐DFS ☐DMH/DD/SAS ☐DSS

Number of Calendar Days from Receipt to Completion: _____

Written feedback of final disposition/resolution was provided to:

Person completing this form:	**Date:**